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Published in:
Children and Youth Services Review

DOI:
10.1016/j.childyouth.2020.104856

Publication date:
2020

Children and Youth Services Review 111 (2020) 104856

Contents lists available at ScienceDirect

Children and Youth Services Review

journal homepage: www.elsevier.com/locate/childyouth

Elucidating care for families with multiple problems in routine practice: Self-registered practice and program elements of practitioners

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ARTICLE INFO

Keywords:
Child and adolescent social care
Families with multiple problems
Practice elements
Program elements
Interventions

ABSTRACT

Families with multiple problems (FMP), also defined as multiproblem families or multistressed families, face multiple, severe, chronic and intertwined problems in different areas of life. Content and provision of interventions targeting FMP in routine practice may largely deviate from guidelines in intervention manuals. The aim of this study was to identify practice and program elements provided to FMP in routine practice, including the intensity, manner of provision, and recipients, per intervention phase (starting-, care- and end phase). We selected interventions with at least moderate ($d \geq 0.5$) effect sizes in the Dutch context, yielding eight interventions. Practitioners of 26 Dutch organizations systematically registered information on practice and program elements, intensity, manner of provision, and recipients, using the taxonomy of interventions for FMP. Within 474 trajectories we found that elements regarding activation of the social network of FMP were provided least often (in less than 48–77% of the families). Elements were provided mainly through psycho-education (25–33%) and instruction (21–24%). Interventions focused more on parents (53–62%) than on children (26–32%). Program elements hardly changed between phases of interventions, although the number of visits decreased (from an average of six visits a month during the starting phase to four visits during the end phase). An inventory of elements that make part of interventions for FMP allows studying the effectiveness of these interventions in a more detailed way. This yields information that may help to identify the optimal sequence, intensity and duration of elements and enables to better understand outcomes of interventions for FMP.

1. Introduction

Families with multiple problems (FMP), also defined as multiproblem families or multistressed families, face multiple, severe, chronic and intertwined problems in different areas of life (Morris, 2013; Spratt & Devaney, 2009; Tausendfreund, Knot-Dickscheit, Schulze, Knorth, & Grietens, 2016). These problems could regard combinations of behavioural problems of the child, parenting problems, family conflicts and health and financial problems (Bodden & Deković, 2016). Because of these problems, the child may be at risk for out of home placement. Over the years, various interventions aimed at reducing difficulties of families with multiple problems (FMP) have been developed. Well-known examples of these interventions include Multisystemic Therapy (MST) and Multidimensional Family Therapy (MDFT) (Ogden & Hagen, 2006; van der Pol et al., 2017). These interventions focus in particular on improving parenting skills, reducing problem behaviour of the child, and preventing out of home placement of the child. Effectiveness studies have shown beneficial effects for some of these interventions on domains such as problem behaviour of the child and/or parenting stress (Asscher, Deković, Manders, van der Laan, & Prins, 2013; van der Pol et al., 2017; van der Stouwe, Asscher, Stams, Deković, & van der Laan, 2014).

Interventions for FMP focus on a wide array of life domains and their interconnections, enabling practitioners to take into account the complexity of problems of these families (Tausendfreund et al., 2016). Moreover, interventions typically address the family as a system

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https://doi.org/10.1016/j.childyouth.2020.104856
Received 8 October 2019; Received in revised form 12 February 2020; Accepted 12 February 2020
Available online 13 February 2020

because problems of FMP may involve all family members, with those affected also influencing each other. Another important characteristic of these interventions is that they are provided mainly in the home environment. The idea behind this practice is to tailor interventions to the situation at home, so that families are able to apply learned skills more effectively (Burns, Schoenwald, Burchard, Faw, & Santos, 2000; Henggeler & Schaeffer, 2016; Snell-Johns, Mendez, & Smith, 2004). Finally, the interventions are usually provided in a time-dependent manner, being more intense during the starting phase and less intense during the end phase.

A recent study unravelled the theoretical content of interventions for FMP (Visscher et al., 2020), but still, little is known about their actual content and provision in routine practice. In routine practice this content deviates quite frequently and quite much from thorough descriptions of the interventions in intervention manuals (Fixsen, Naoom, Blasé, Friedman, & Wallace, 2005; Goense, Assink, Stams, Boendermaker, & Hoeve, 2016). This may be the case for several reasons. First, the shifting needs and problems of FMP during the intervention may complicate application of the intervention as documented in the manual (Goense et al., 2016). Second, the time and financial pressure faced by care providers and practitioners themselves may influence the content of interventions in routine practice (Weisz, Ng, & Bearman, 2014). Such pressure may, for example, encourage child and adolescent social care (CASC) organizations and practitioners to reduce costs by excluding elements of the intervention, such as parts of the intervision and supervision for practitioners.

More comprehensive information on the content and provision of interventions for FMP in routine practice is needed, to better interpret outcomes of care. Such information can indicate whether adapted or incomplete implementation of these interventions results in smaller effect sizes than found in more controlled settings (Craig et al., 2013; Weisz et al., 2014). This detailed information on care provided in routine practice helps to study the effectiveness of interventions: will the provision of certain elements lead to more positive outcomes for FMP compared to trajectories within which these elements are not provided? Furthermore, knowledge on the sequence and intensity in which elements are provided during an intervention can be a first step towards identifying the optimal sequence, intensity and duration of elements within the interventions (Lee et al., 2014). This enables matching of interventions to the specific problems of FMP and in this way to improve the quality of care for these families.

One way to gain knowledge on the content and provision of interventions for FMP in routine practice is the use of the taxonomy of interventions for FMP (TIFMP). This taxonomy has been developed based on existing taxonomies of interventions for FMP, information from manuals of eight interventions targeting FMP and knowledge from intervention experts (Visscher et al., 2018). The TIFMP consists of 53 practice elements and eight program elements, which makes it possible to systematically identify the content of a wide range of interventions targeting FMP (Visscher et al., 2018). Practice elements have to do with the content of an intervention, as they are distinct techniques (such as modelling, social skills training) provided by the practitioner to promote positive outcomes. Program elements are aspects of the intervention format, or the service delivery system (such as 24-hour reachability), that may affect the results (Lee et al., 2014). Using this taxonomy for systematic collection of information from practitioners, enables us to gain detailed knowledge on (ways in) which elements are provided to FMP. We aimed in this study to identify the practice and program elements provided to FMP in routine practice, including the intensity, the recipients and the methods by which they were provided, per intervention phase. This knowledge is important for our understanding of care for FMP in general and enables to draw inferences on which elements are effective for whom and in which way (i.e., through which method and with which intensity). With this knowledge, concrete recommendations can be given on effective ways to provide care to FMP.

2. Method

To explore the content and provision of interventions for FMP we asked practitioners to systematically record information about which practice and program elements they provided in care for FMP, the intensity, the recipients and the methods by which they were provided. This information was registered by means of the taxonomy of interventions for FMP (TIFMP) (Visscher et al., 2018).

2.1. Selection of interventions

We searched for interventions in a systematic review of the literature on 30 interventions targeting FMP (Evenboer, Reijneveld, & Jansen, 2018). We selected eight interventions targeting FMP, all of which in the Dutch context had at least a moderate effect size of $d = 0.5$ on domains such as problem behaviour of the child or parenting stress. The eight interventions were: Multisystemic Therapy (MST), Multidimensional Family Therapy (MDFT), Intensive Family Treatment (IFT), Families First (FF), Family Central (FC), Parent Management Training Oregon (PMTO), 10 for the Future (10FtF) and Triple P 4–5 (Evenboer et al., 2018). The target group of these interventions are families in which there are severe parenting problems, families in which the child has severe behavioural problems (MST, MDFT, PMTO and Triple P 4/5) and families with multiple and complex problems in different life domains (like severe parenting, socio-economic and mental health problems; IFT, FF, FC and 10FtF). More information on these interventions can be found in Table 1. In this study, FMP refers to families that received one of these eight interventions due to their problems in multiple domains.

2.2. Sample

Forty-seven CASC organizations across the Netherlands were approached to participate in this study. Each organization worked with one or more of the selected interventions. Of the 47 organizations approached, 26 were willing to participate, and provided practitioners (child and family social workers, family coaches and therapists) to participate in this study. Organizations that did not want to participate indicated that they already took part in another study or did not want to spend their scarce manpower and resources to participating in a study. The organizations that did not want to participate did not deviate from organizations that did participate regarding size and target population. Practitioners reported on the content of 130 MST, 58 MDFT, 236 IFT, six FC, 33 PMTO and 11 10FtF trajectories. We excluded Triple P 4–5 and FF because questionnaires were filled out for only one family that received Triple P 4–5 and nine families that received FF. In addition, the duration of these interventions (2–2.5 months and one month, respectively) did not allow us to divide these interventions in intervention phases (starting-, care- and end phase), consisting of four weeks periods. Furthermore, we included only families with care trajectories in which the targeted child was between 4 and 20 years of age at the start of the intervention. Questionnaires about twelve families with care trajectories were excluded because the child was younger than four years of age at the start of the intervention. After excluding questionnaires about these care trajectories, the total sample consisted of 474 families with care trajectories.

2.3. Procedure and measures

The TIFMP is a taxonomy to systematically measure practice elements and program elements (Visscher et al., 2018). For the aim of this study we converted the TIFMP into a web-based questionnaire to be filled in by practitioners for families who had given informed consent. We sent these practitioners an email asking them to fill in the TIFMP every four weeks during the entire intervention. When taxonomies were filled in within two weeks of each other, we excluded one of the two

Table 1
Background information on the eight selected interventions.

Intervention	Duration	Aim of the intervention, target group, focus of the intervention and theory of change
Parent Management Training Oregon (PMTO)	5 months	PMTO aims to provide parents with more systematic and effective parenting strategies to enhance their relationships with their children and reduce the number of conflicts. The target group is parents with children between 4 and 12 years who show severe externalizing problem behaviour in combination with hyperactivity. The focus of the intervention is to reinforce positive behaviour in the parents/child(ren). The intervention uses the social interaction learning theory as theory of change
Multisystemic Therapy (MST)	3–5 months	MST aims to provide intensive treatment in a home-based situation to prevent out of home placement. The target group is children from 12 to 18 years with severe antisocial/border-crossing behaviour, and their parents. Problems could occur in multiple life domains and could lead to out of home placement of the child. The intervention focuses on the child, family, friends, school and peers. This intervention uses the social ecological theory of Bronfenbrenner as theory of change
Multidimensional Family Therapy (MDFT)	3–7 months	MDFT aims to reduce criminal and addictive behaviour and related behavioural and emotional problems of the child, to enhance communication within the family, and to increase the social cohesion. The target group is youth from 12 to 19 years with multiple problem behaviour like delinquency and/or addiction, complemented by school truancy. At least one parent should join the therapy. The intervention focuses on the child and his family and peers. It uses the social ecological theory of Bronfenbrenner as theory of change
Intensive Family Treatment (IFT)	5–7 months	IFT aims to reduce children's problem behaviour and parental stress, and to increase parenting skills and activate the social network of the family. The target group is families with children between 0 and 23 years with multiple and complex problems in different life domains. These families can be stubborn and difficult for the therapist to reach. The intervention focuses on preventing out of home placement or reunification. The intervention uses goal-driven work as theory of change
Families First (FF)	1 month	FF aims to reduce the problem behaviour of the child and strengthen the competencies of the family, thereby reducing parenting stress, increasing parenting skills and activating the social network of the family. The target group is families in an acute crisis, serious enough to risk of out of home placement of the child. The focus is on managing the crisis and assuring the safety of the family members. The intervention uses the competence model as theory of change
Family Central (FC)	6–12 months	FC aims to enhance communication between family members and collaboration between parents, thereby reducing behavioural problems of the child(ren) and activating the social network of the family. The target group is youth between 0 and 18 years, and their family, who could have serious parenting problems and and developmental problems. These families can be stubborn and difficult for the therapist to reach. The focus is on the accumulation of problems and trying to find balance in the various domains of life. The intervention uses the competence model, goal-driven working and working according to a system approach as theories of change
10 for the Future (10FtF)	12 months	10FtF aims to provide assistance on ten different areas of life: household work, education, self-care, development of the child, enhancing the social network, finance, parenting skills, daily routine, psychosocial and addiction problems and coordination of care. The target group is families with complicated and multiple problems in different life domains, with a risk of out of home placement of the child. The focus is on a safe environment for the child(ren) and parent(s). The intervention uses goal-driven working as theory of change
Triple P 4–5	2–2.5 months	Triple P aims to prevent children from having serious behavioural and emotional problems by enhancing parental competencies. The target group of Triple P 4 is parents who have children with severe behavioural problems and are in need of a targeted training in parenting skills. The target group of Triple P 5 is families with multiple behavioural problems combined with other family related problems. Level 5 is deployed when no or insufficient improvement is seen in the behaviour of the child after level 4 because parenting problems are linked with other problems (e.g., depression, stress or relational problems). The intervention uses the social learning theory, the theory of behavioural change and the social information theory as theories of change

(n = 14), because they contained information on practice and program elements provided (for the most part) in overlapping weeks.

Questions on *practice elements* had to do with the content of care that had been offered in the preceding four weeks. Practitioners were asked, per main category of the TIFMP, to select the practice elements that were provided to the family. This could include 53 practice elements, divided into eight main categories:

A. Assessment of problems: practice elements that aim to collect and categorise information about the family and problems they experience (e.g., analysis of competencies)
B. Planning and evaluation: practice elements that aim to translate problems of the family into goals and practice elements involving the evaluation of these goals (e.g., designing the treatment plan)
C. Working on change: practice elements that aim to realize change (e.g., working on communication and interaction)
D. Learning parenting skills: practice elements that aim to improve parenting skills (e.g., learning to set rules)
E. Helping with concrete needs: practice elements that aim to ease the burden of practical everyday challenges (e.g., helping with financial tasks)
F. Activating the social network: practice elements that aim to engage the social network around the family in helping and supporting the family (e.g., mobilizing and expanding the social network)
G. Activating the professional network: practice elements that aim to enhance goals, appointments and procedures that regard other practitioners who work with the family (e.g., coordinating the approach with other professionals and/or organizations working with the family)
H. Maintaining practitioner-client collaboration: practice elements that aim to maintain and promote the collaboration between the practitioner and the client (e.g., talking about expectations).

After the selection of provided practice elements, we further collected data on the intensity in which the practice elements were provided. At each registration moment, for each selected practice element practitioners were asked whether during the preceding four weeks they had provided the recorded practice element in every visit, in more than half but not all of the visits, or in fewer than half of the visits.

We also collected data on the recipients of registered practice elements. At each registration moment, for each selected practice element practitioners were asked to fill in to whom the practice element was provided. Answer categories were: the child, parent(s), sibling(s) and/or other persons outside the family. For practice elements from main category D the recipients were not registered because these practice elements focus specifically on learning skills for parent(s).

Lastly, we collected data on methods by which practice elements within categories C, D and E were provided. After selecting a practice

element out of the categories C or D, practitioners were asked by which method the element was provided. Answer categories were: psychoeducation, instruction, modelling and/or giving homework. After selecting practice elements out of category E the answer categories were: helping themselves, giving advice, or referring the family to another person or organization.

Regarding program elements, we collected information on the following elements: the intensity of visits (how often did you visit the family), duration of visits (how many minutes on average did these visits last), phone contacts in between the visits (did you had any phone contact with the family in between contacts; yes/no), receipt of intervision (discussing a family with colleagues during an organized meeting; yes/no), receipt of supervision (discussing a family with a supervisor during an organized meeting; yes/no) and receipt of consultation (discussing a family with an independent expert during an organized meeting; yes/no). Lastly, we asked if the practitioner was 24-hours reachable for the family. Answer categories were: (a) Yes, I was 24-hours reachable (b) No, I was not 24-hours reachable but a colleague was reachable (c) No, there is no 24-hours reachability service, or (d) Other.

We divided each intervention into three phases because of differences in the durations both of the interventions and of the individual care trajectories. Three phases were defined that are part of every formal longer lasting care process and typically entail different care processes. Phases are in accordance with the descriptions of phases in the intervention manuals of the eight included interventions and were checked during a field consultation with intervention experts (at least one per intervention). These phases were the starting (T1), the care (T2) and the end phase (T3). We then categorized each questionnaire according to the phase it applied to: the starting (T1), the care (T2), or the end phase (T3). The criteria used to categorize a questionnaire in a specific phase can be found in Table 2.

2.4. Analysis and reporting

First, we described the characteristics of the sample. Second, we explored provided practice elements (including their intensity), to whom the practice elements were provided, and the methods by which they were provided. Third, we assessed program elements of interventions for FMP in routine practice. We described the results per phase (starting-, care- and end phase). When for one family questionnaires were filled in for several four-week periods during one phase, the results of these questionnaires were combined. For example, when for one family three questionnaires were filled in during the care phase (because the care phase had a duration of three months) the results of these questionnaires were combined. Thus the results in this paper give information on all practice and program elements registered for that family during each of these three phases.

We used descriptive statistics (frequencies, proportions and means) to explore the provided practice and program elements of interventions within these phases. In addition, we used Chi-square tests to determine whether the provision of main categories differed between the intervention phases and whether the provision of elements differed between the starting-, care- and end phases of interventions.

3. Results

3.1. Background of samples

Regarding visits in the starting phase of the interventions, 256 questionnaires concerning 246 families were completed (53 MST, 41 MDFT, 9 PMTO, 134 IFT, 6 10FtF and 3 FC). Regarding visits in the care phase, 1670 questionnaires concerning 436 families were completed (117 MST, 54 MDFT, 32 PMTO, 216 IFT, 11 10FtF and 6 FC). Regarding visits in the end phase, 230 questionnaires for 220 families were completed (72 MST, 20 MDFT, 17 PMTO, 102 IFT, 4 10FtF and 5 FC).

Table 2
Classification of interventions.

Intervention	Duration of intervention	Starting Phase (T1)	Care phase (T2)	End phase (T3)
Family Central (FC)	6–12 months	First 42 days	Between day 43 and 14 days before the end date	Between 14 days before and 14 days after the end date
Intensive Family Therapy (IFT)	5–7 months	First 42 days	Between day 43 and 14 days before the end date	Between 14 days before and 14 days after the end date
Multisystemic Therapy (MST)	3–7 months	First 42 days	Between day 43 and 14 days before the end date	Between 14 days before and 14 days after the end date
Multidimensional Family Therapy (MDFT)	3–5 months	First 42 days	Between day 43 and 14 days before the end date	Between 14 days before and 14 days after the end date
Parent Management Training Oregon (PMTO)	5 months	First 42 days	Between day 43 and 14 days before the end date	Between 14 days before and 14 days after the end date
10 for the Future (10FtF)	12 months	First 70 days	Between day 71 and 28 days before the end date	Between 28 days before and 14 days after the end date.

Note. Table displays the days within with the questionnaire has to be filled in to be regarded as a questionnaire on the starting phase, care phase or end phase.

The greater number of questionnaires for the care phase was due to the longer duration of this phase.

3.2. Provision, intensity, methods and recipients of practice elements of interventions for FMP in routine practice, per phase

During the interventions, elements out of the main categories 'assessment of problems', 'planning and evaluation', 'working on change', 'learning parenting skills' and 'maintaining the practitioner-client collaboration' are most often provided to FMP (ranging from 75.0% to 98.0% between phases). During the starting phase of the interventions, practitioners most often registered practice elements within the main categories 'assessment of problems' (98.0% of FMP), 'planning and evaluation' (90.2%), 'working on change' (89.4%) and 'maintaining the practitioner-client collaboration' (95.1%). Regarding visits in the care phase, practitioners most often registered practice elements within the main categories 'assessment of problems' (98.2%), 'planning and evaluation' (97.9%), 'working on change' (98.4%), 'learning parenting skills' (97.9%), and 'maintaining practitioner-client collaboration' (97.2%). Regarding visits during the end phase practitioners registered practice elements primarily within the main categories 'planning and evaluation' (85.9%), 'working on change' (83.2%) and 'maintaining practitioner-client collaboration' (87.3%).

Relatively fewer of the provided practice elements were related to the main categories 'helping with concrete needs' and 'activating the social network'. From both of these categories, respectively 61.8% and 64.2% of the families received at least one element during visits in the starting phase. Families received at least one practice element from the main category 'activating the social network' during visits in the care phase (76.8% of the families) and end phase (47.7% of the families). As for the main category 'helping with concrete needs', 83.0% of the families received at least one practice element during visits in the care phase and 49.5% during visits in the end phase.

Regarding the intensity in which practice elements were provided, during all phases practitioners registered that in most families provision of elements from the main categories 'assessment of problems', 'planning and evaluation', 'working on change', 'learning parenting skills', and 'maintaining practitioner-client collaboration' took place in more than half or all of the visits (i.e., high intensity). In contrast, during all phases practitioners registered that in most families provision of elements out of the main categories 'helping with concrete needs', 'activating the social network' and 'activating the professional network' took place in fewer than half of the visits to families (i.e., low intensity).

Chi-square tests showed that the main categories as provided differed significantly between the three phases, as shown in Table 3. Also, the provided elements differed significantly between the starting-, care-, and end phases of interventions. In addition, Post-hoc tests with Bonferroni correction (with significance levels set at 0.0167) showed that elements from all main categories were provided significantly more often in the care phase, than during the end phase. Elements concerning 'assessment of problems', 'helping with concrete needs', 'activating the social network' and 'maintaining the practitioner-client collaboration' were provided significantly more often during the starting phase, than during the end phase. Elements concerning 'planning and evaluation', 'working on change', 'learning parenting skills', 'helping with concrete needs', 'activating the social network' and 'activating the professional network' were provided significantly more often during the care phase, than during the starting phase.

Table 3 provides an overview of the absolute and relative proportions of the registered main categories and registered practice elements per category and per phase, including the intensity of provided practice elements. Additionally, results of the Chi-square and post-hoc tests are provided for each main category and each element.

Of all registered persons provided with practice elements, parents were the largest group: 56% of all registered recipients in the starting phase, 53% during the care phase and 62% during the end phase. Of all registered recipients during both the starting and care phases 32% were children, and during the end phase 26%. Further registered recipients were siblings: 8% during the starting phase, 9% during the care phase and 6% during the end phase. Finally, other persons associated with the family, such as teachers or grandparents, were least often recipients of practice elements (4% during the starting phase, and 6% during both the care and end phases).

Of all methods by which practice elements were provided, psycho-education was the method most often registered. However, the percentages of psycho-education provided decreased towards the end phase (33% of all registered methods during the starting phase, 26% during the care phase and 25% during the end phase). After psycho-education, instruction was second in importance (during the starting phase 24% of all registered methods, during the care phase 23%, and during the end phase 21%).

Practice elements from main category E (helping with concrete needs) mainly took the form of advice given by the practitioners to families (59% of all registered methods during the starting phase). This percentage gradually became slightly lower (58% during the care phase and 55% during the end phase). More detailed information on the methods by which practice elements were provided during the different phases can be found in Figs. 1 and 2.

3.3. Provision of program elements of interventions for FMP in routine practice, per phase

The intensity and duration of the face-to-face visits decreased towards the end of the interventions, although the decline in duration of visits was quite small. The intensity and duration of visits decreased from an average of six times a month for an average of 83 min per visit (starting phase), via an average of five times a month with an average of 79 min (care phase) to an average of four times a month with an average of 71 min (end phase). The phone contacts in between these visits were most frequent during the care phase (at least once in 68% of the families during the starting phase, 87% during the care phase, and 68% during the end phase).

Regarding all phases, practitioners received more supervision (e.g., discussing the family with a supervisor during an organized meeting) than intervision (e.g., discussing the family with colleagues during an organized meeting), while consultation (e.g., discussing the family with an independent expert during an organized meeting) was least often provided. Supervision was provided at least once to practitioners: during the starting phase regarding 78% of the families, during the care phase regarding 86%, and during the end phase regarding 64%. Intervision took place at least once: during the starting phase regarding 68% of the families, during the care phase 75%, and during the end phase 45%. Consultation was least often received. Practitioners received consultation at least once regarding 39% of the families during the starting phase, 55% during the care phase, and 46% during the end phase.

As for the reachability of practitioners, for most families there was no 24-hour reachability, although for some families a colleague of the responsible practitioner was available. There was no 24-hour reachability for 46% of the families (starting phase), 41% (care phase) and 39% (end phase). Of the families concerned, 43% (starting phase), 49% (care phase) and 53% (end phase) the responsible practitioner reported that where he/she had not provided 24-hour reachability, another practitioner had been available. For 3% of the families concerned (starting phase), 4% (care phase), and 2% (end phase), the practitioner had been available for 24 h. In 8% of the families concerned (starting phase), 5% (care phase) and 6% (end phase) practitioners indicated 'other'. They mentioned, for example, that they were reachable during working hours, that there was a general reachability service within the organization, that other organizations involved with the family offered 24-hour reachability, or that it was not necessary to be reachable.

Table 3
Registered practice elements within the main categories, their intensity and results from Chi-Square tests.

Practice elements	Percentage of families for whom the practice elements were registered at least once during the phase, and most frequently registered intensity						Differences in provided elements between intervention phases (Results of Chi-Square tests)		
	Starting phase (n = 246)		Care phase (n = 436)		End phase (n = 220)		Starting vs. Care phase	Starting vs. End phase	Care vs. End phase
	%	intensity	%	intensity	%	intensity	p	p	p
(A) Assessment of problems[a]	98.0		98.2		75.0		0.856	< 0.001*	< 0.001*
Discussing the guiding question	97.2	+ +	93.6	+	58.6	+ +	0.042	< 0.001*	< 0.001*
Analysis of competencies	80.5	+	75.9	+	24.1	+ +	0.169	< 0.001*	< 0.001*
Analysis of network	74.0	−	67.0	−	20.5	−	0.056	< 0.001*	< 0.001*
Analysis of safety	75.6	−	67.2	+	22.3	+ +	0.021	< 0.001*	< 0.001*
Analysis of family system	90.2	+ +	81.4	+ +	29.1	+ +	0.002*	< 0.001*	< 0.001*
Analysis of leisure time	72.0	−	62.4	−	18.2	+	0.011*	< 0.001*	< 0.001*
Analysis of school functioning	81.7	−	78.9	−	29.5	+	0.379	< 0.001*	< 0.001*
Analysis of daily routine	77.2	−	73.2	+	20.5	+ +	0.241	< 0.001*	< 0.001*
Analysis of individual problems	79.3	+	77.5	+	23.6	+ +	0.596	< 0.001*	< 0.001*
Using homework assignments to observe and register behaviour	43.5	−	69.0	+	31.4	+	< 0.001*	0.007*	< 0.001*
Using questionnaires	66.3	−	47.2	−	18.6	−	< 0.001*	< 0.001*	< 0.001*
Discussing results from questionnaires	40.2	−	41.1	−	16.8	−	0.836	< 0.001*	< 0.001*
Problem assessment	77.6	+	86.5	+	32.3	+ +	0.003*	< 0.001*	< 0.001*
(B) Planning and evaluation[a]	90.2		97.9		85.9		< 0.001*	0.148	< 0.001*
Designing treatment plan	75.2	−	73.9	−	20.9	−	0.698	< 0.001*	< 0.001*
Designing working points or (behavioural) agreements	79.9	+	90.4	+	36.4	+ +	< 0.001*	< 0.001*	< 0.001*
Evaluating working points or (behavioural) agreements	54.1	+ +	91.7	+	72.3	+ +	< 0.001*	< 0.001*	< 0.001*
Evaluating treatment plan	32.5	−	78.4	−	69.1	+	< 0.001*	< 0.001*	0.009*
(C) Working on change[a]	89.4		98.4		83.2		< 0.001*	0.049	< 0.001*
Working on recognizing, avoiding and coping with situations eliciting problem behaviour, and help with eliminating these causes.	75.6	+ +	95.0	+	45.0	+	< 0.001*	< 0.001*	< 0.001*
Working on thoughts	50.0	−	76.1	+	38.6	+	< 0.001*	0.014*	< 0.001*
Working on emotions	54.5	+	79.6	+	37.7	+	< 0.001*	< 0.001*	< 0.001*
Working on desired behaviour	67.9	+ +	91.5	+ +	58.2	+ +	< 0.001*	0.030	< 0.001*
Working on undesired behaviour	49.2	+ +	73.6	+	37.7	+	< 0.001*	0.013*	< 0.001*
Working on communication and interaction	76.8	+ +	91.5	+ +	62.7	+ +	< 0.001*	0.001*	< 0.001*
Working on authority relationships	57.7	+ +	79.6	+	40.9	+	< 0.001*	< 0.001*	< 0.001*
Working on daily routine	43.9	−	65.4	+	28.2	−	< 0.001*	< 0.001*	< 0.001*
Working on safety	46.7	+ +	62.4	−	25.5	+	< 0.001*	< 0.001*	< 0.001*
Working on generalization	28.5	+	65.6	+	50.9	+ +	< 0.001*	< 0.001*	< 0.001*
(D) Learning parenting skills[a]	82.1		97.9		77.3		< 0.001*	0.194	< 0.001*
Learning to apply reinforcements and positive consequences	54.9	−	82.3	+	42.7	+	< 0.001*	0.009*	< 0.001*
Learning to apply mild punishments and negative consequences	43.1	−	69.7	+	35.5	+	< 0.001*	0.092	< 0.001*
Learning to monitor the child	35.8	+	55.3	−	29.1	−	< 0.001*	0.125	< 0.001*
Learning to show commitment to the child	41.5	+	66.7	+	37.3	+	< 0.001*	0.356	< 0.001*
Learning to handle conflicts	50.4	+	77.3	+	43.2	+	< 0.001*	0.119	< 0.001*
Learning to set rules	56.5	+	79.6	+	36.4	+	< 0.001*	< 0.001*	< 0.001*
Learning to be responsive	40.7	+	67.2	+	32.3	+	< 0.001*	0.061	< 0.001*
Learning to perform social skills	27.6	+	45.9	+	17.3	−	< 0.001*	0.008*	< 0.001*
Learning to collaborate	48.4	−	71.6	+	43.6	−	< 0.001*	0.306	< 0.001*
(E) Helping with concrete needs[a]	61.8		83.0		49.5		< 0.001*	0.008*	< 0.001*
Self-care	24.4	−	39.2	−	16.4	−	< 0.001*	0.032	< 0.001*
Administration and financial control	17.5	−	29.8	−	10.0	−	< 0.001*	0.020	< 0.001*
Contact with school and/or other authorities	54.1	−	78.2	−	44.5	−	< 0.001*	0.040	< 0.001*
Housekeeping	16.7	−	24.1	−	7.7	−	0.023	0.004*	< 0.001*
(F) Activating social network[a]	64.2		76.8		47.7		< 0.001*	< 0.001*	< 0.001*
Mobilizing and expanding social support	37.0	−	55.3	−	30.5	−	< 0.001*	0.137	< 0.001*
Maintaining the social network	31.7	−	52.8	−	28.2	−	< 0.001*	0.407	< 0.001*
Stimulating leisure time	50.0	−	66.3	−	32.7	−	< 0.001*	< 0.001*	< 0.001*
(G) Activating professional network[a]	71.5		86.9		72.7		< 0.001*	0.776	< 0.001*
Collaborating with other professionals and/or organizations working with the family	67.5	−	84.4	−	68.6	−	< 0.001*	0.789	< 0.001*
Coordinating the approach with other professionals and/or organizations working with the family	32.5	−	48.6	−	28.2	−	< 0.001*	0.310	< 0.001*
Referring to other organizations or authorities	24.8	−	50.0	−	34.5	−	< 0.001*	0.021	< 0.001*
Organizing respite care	11.0	−	16.5	−	6.4	−	0.049	0.079	< 0.001*

(*continued on next page*)

Table 3 (*continued*)

Practice elements	Percentage of families for whom the practice elements were registered at least once during the phase, and most frequently registered intensity						Differences in provided elements between intervention phases (Results of Chi-Square tests)		
	Starting phase (n = 246)		Care phase (n = 436)		End phase (n = 220)		Starting vs. Care phase	Starting vs. End phase	Care vs. End phase
	%	intensity	%	intensity	%	intensity	p	p	p
(H) Maintaining practitioner-client collaboration[a]	95.1		97.2		87.3		0.148	0.003*	< 0.001*
Talking about expectations	85.4	+	89.0	+	51.8	+ +	0.167	< 0.001*	< 0.001*
Talking about resistance to care	44.7	–	59.9	–	30.5	–	< 0.001*	0.002*	< 0.001*
Working on motivation	57.3	+ +	69.3	+ +	35.0	+ +	0.002*	< 0.001*	< 0.001*
Offering emotional support	82.9	+ +	91.1	+ +	58.2	+ +	0.002*	< 0.001*	< 0.001*
Working on quality of relationship	80.5	+ +	85.6	+ +	45.9	+ +	0.085	< 0.001*	< 0.001*
Evaluating relationship	54.1	–	74.1	–	64.1	–	< 0.001*	0.028	0.008*

Intensity: – = element provided in fewer than half of visits in majority of families; + = element provided in more than half of visits in majority of families; + + = element provided in each visit in majority of families.

[a] Percentages for main categories show the families in which at least one element out of this category was provided.

* Bonferroni corrected significance of P ≤ 0.0167.

4. Discussion

The aim of this study was to identify the practice and program elements provided to FMP in routine practice, including the intensity, the methods by which provided, and the recipients, per phase (starting phase, care phase and end phase). Regarding practice elements, our study showed that elements most often provided were within the main categories 'assessment of problems', 'planning and evaluation', 'working on change', 'learning parenting skills' and 'maintaining the practitioner-client collaboration'. Elements within these main categories were usually provided in a high intensity (e.g., in more than half of the visits or in every visit) during all phases. The higher frequency of these main categories is in line with previous findings on the elements that are part of the interventions for FMP as described in their manuals. Elements from these categories are often part of interventions for FMP, according to their manuals (Visscher et al., 2020).

Elements from the main categories 'activating the social network' and 'helping with concrete needs' were least often provided to the FMP. When elements from these two categories and from the main category 'activating the professional network' were provided, in all phases these were usually provided in fewer than half of the visits. This finding is also in line with previous findings, based on descriptions of these interventions in their manuals, since elements from these main categories are more often intervention-specific elements (i.e., part of only a small number of the interventions for FMP) (Visscher et al., 2020). In addition, interventions focused more on parents and less on children. Of the methods by which practice elements were provided, psycho-education was the most frequent. Finally, although the program elements as included in the interventions hardly differed between the subsequent phases, towards the end of the interventions the number of face-to-face visits decreased.

During the care and end phases, practitioners were least often working on activating the social network around the family; consequently, the social network was not often involved as a care recipient. This is in line with the finding of Tausendfreund et al. (2015) who showed that within care for FMP solutions and support in the environment of the family were seldom sought. Studies on the effects of including these social networks of FMP within interventions are inconsistent. Some studies suggest inclusion to be beneficial, as it can facilitate engagement and help to maintain change within these families (Cunningham & Henggeler, 1999). Other studies suggest that the social networks of FMP may not contribute to positive change because of characteristics like instability, lack of positive parenting norms, or reinforcement of neglectful parenting norms (Bodden & Deković, 2016; Fernandez, 2007; Sousa, 2005). Activating the social network of FMP thus calls for further study on the most effective ways of delivery.

Our study further showed that parents were the main care recipients of practice elements in interventions for FMP, confirming studies reporting that within FMP more attention is generally paid to parents than to children (Knorth, Knot-Dickscheit, & Thoburn, 2015; Tausendfreund, Knot-Dickscheit, Post, Knorth, & Grietens, 2014; Tausendfreund et al., 2015). In the interventions most underlying theories of change aim to address the complete environment surrounding a child. Another theory, for example that of PMTO, may explain this finding. This social interaction theory suggests that as children's behaviour is directly affected by parenting, parents play an important role

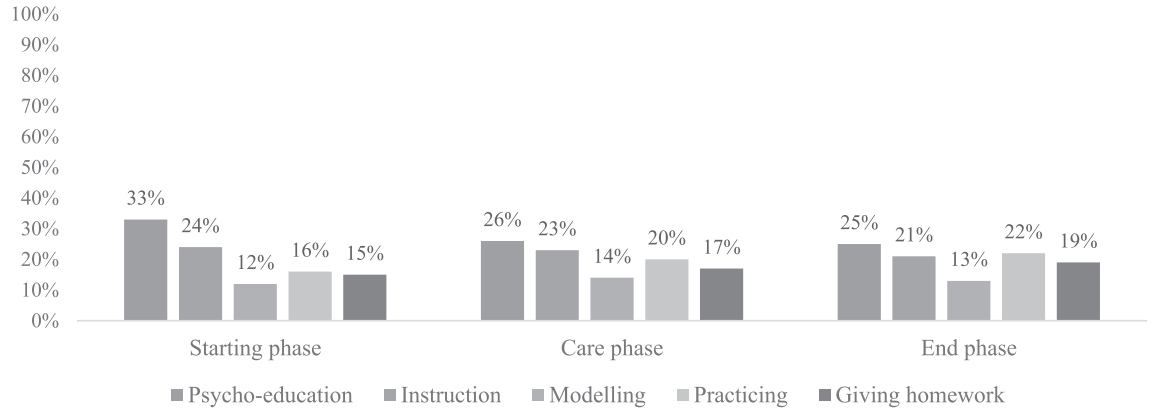

Fig. 1. Methods by which practice elements within main categories C (working on change) and D (learning parenting skills) were provided.

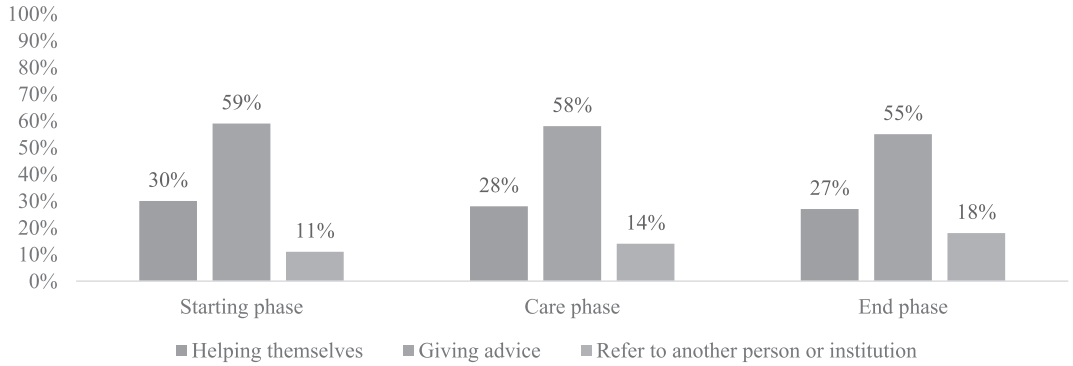

Fig. 2. Methods by which practice elements within main category E (helping with concrete needs) were provided.

in breaking patterns of interactions. They can do this by learning effective discipline, monitoring, and problem solving (Ogden & Hagen, 2008). Another explanation for the focus on parents could be that because some interventions for FMP (PMTO, IFT, FC and 10FtF) address children younger than twelve years of age, practitioners focus mainly on teaching the parents the skills to cope with their child's behaviour based on the assumption that they cannot directly address young children. These reasons may explain this finding, but the finding anyhow contradicts the labelling of interventions targeting FMP as interventions that address the family as a system. Our study demonstrates that this holds only to a rather limited degree.

During all care phases, the main method by which the practice elements were provided appeared to be psycho-education. Through psycho-education practitioners provide information and support to the family to better understand and cope with certain behaviour (Zhao, Sampson, Xia, & Jayaram, 2015). They do this, for example, by explaining why and how a child presents the behaviour. The frequent use of psycho-education implies that practitioners talk a lot with families, and that they less often practice behaviour, give homework, or demonstrate behaviour. This high ratio of psycho-education may not suit the needs of FMP, since these families seem to benefit more from practical help (e.g., practicing or modelling behaviour) than from talking (Holwerda, Reijneveld, & Jansen, 2014). Moreover, as many parents and/or children from FMP have cognitive disabilities, often resulting in lower educational levels and lack of knowledge (Bodden & Deković, 2016), it could be even more difficult for them to benefit from psycho-education. Our findings showed that psycho-education is frequently used as a way to provide practice elements targeting FMP. However, further studies should examine whether this use of psycho-education meets the needs of FMP or whether a greater focus on other practice elements, like modelling or practicing behaviour, would improve outcomes.

Regarding program elements, we found that duration of visits, intervision, supervision, consultation and 24-hour reachability hardly changed between phases, although the intensity (number of visits) of the interventions decreased towards the end phase. The declining number of visits clearly reflects the sequencing of the phases of interventions, which is also described in the manuals of the included interventions (Visscher et al., 2020). In these intervention manuals, this sequencing is often recorded as a suggestion of the number of visits per phase of the intervention. The idea behind this sequencing of phases is that a family's problems come under control during the intervention, and that then the intensity of the intervention should gradually be phased out (Holwerda et al., 2014). In addition, the number of visits could reflect the needs of the families, because most of the interventions advise matching the number of visits to the family's needs (Carr, 2019). However, it can be questioned whether FMP are indeed likely to become more and more self-supportive during the intervention, and whether the reduction of the number of contacts towards the end of the intervention is advantageous.

4.1. Strengths and limitations

A major strength of this study is the use of an existing taxonomy (TIFMP), developed by using different data sources (e.g., existing taxonomies, national guidelines for FMP, intervention manuals and field experts) (Visscher et al., 2018). This taxonomy enabled practitioners to systematically record information on provided practice and program elements, thereby providing more insight into the actual content of care.

A limitation of our study might be the overrepresentation of certain interventions. The major part of the study consists of data about IFT, MST and MDFT trajectories. PMTO, 10FtF and GC are underrepresented, which may have led to a lack of information on the application of elements within these interventions. However, the overrepresentation of certain interventions unavoidably reflects routine practice, namely the more frequent use of these interventions within the participating CASC organizations. We aimed to identify the elements that are provided to FMP in routine practice and since we include information on the content of interventions that are often provided to FMP, our results can be seen as a reflection of this routine practice of the care for FMP.

4.2. Implications

This study has several implications for practice and research concerning care for FMP. First, within interventions for FMP the lack of emphasis on activating the social network deserves further attention. It could be worthwhile to train practitioners to involve and strengthen these social networks in order to achieve positive change within the families. Moreover, this finding suggests a need for more detailed investigation as to why social networks are not involved (e.g., whether practitioners are unsure of how to involve them), and of ways to strengthen social networks of FMP as part of the interventions (Ayala-Nunes, Nunes, & Lemos, 2017; Sousa, 2005).

Second, our finding that interventions for FMP currently focus most on parents leads to a questioning on the emphasis of interventions. Should this emphasis be shifted more to children, given their importance for positive outcomes (Lee et al., 2014) and the aim of the interventions to reduce the problem behaviour of the child? It may therefore be important to further study care trajectories in which children are addressed more directly and to examine if these trajectories show more positive outcomes than trajectories in which parents are the main care recipients

Third, the frequent use of psycho-education in routine practice deserves further attention, given that FMP benefit more from practical help and repetition of learned skills (Holwerda et al., 2014). Therefore, it could be beneficial to combine psycho-education with more practical help, such as practicing or modelling behaviour. This would enable FMP to use learned skills by themselves, even after the intervention has ended. Further studies should examine the effectiveness of the different

methods (e.g., psycho-education, instruction, modelling and giving homework) in which practice elements are provided.

Fourth, regarding program elements, a next step would be to examine the effect of the declining number of visits towards the end of the interventions, which suggests that practitioners assume that families have an increased ability to cope with behaviour and apply learned skills towards the end of the interventions. Studies should focus on whether this is indeed the case, and on the match between the process of concluding an intervention and the needs of the FMP.

Fifth, the use of our taxonomy to systematically record the content of care in routine practice can provide researchers with new ways to study the effectiveness of interventions. Instead of having information only on the input (i.e., characteristics of families and their problems) and the output of interventions (i.e., outcomes), using self-registered information from practitioners can provide detailed insight into the throughput (practice and program elements) (Tausendfreund et al., 2015). This detailed information on the content of care in routine practice enables to identify if interventions are implemented as intended (i.e., if the elements that are part of interventions according to the manual are really provided in routine practice). In addition, this information on the actual content of care can help to explain differences in outcomes between families, between interventions, and between the same interventions in different countries (Blase & Fixsen, 2013; Evenboer et al., 2018). Moreover, it could improve interpretation of whether, why and for whom certain interventions are effective.

Sixth, this information on the content of care for FMP can help practitioners to reflect on the care they themselves provide, offering new ways to set up supervision of practitioners and to tailor interventions to the needs of specific families, thereby enhancing the quality of care (Tausendfreund et al., 2015; Ruch, 2007), as has already been shown in the case of treatments for anxiety, depression and disruptive behaviour (Borntrager, Chorpita, Higa-McMillan, & Weisz, 2015; Weisz et al., 2012).

5. Conclusion

Our study showed that systematic collection of information on the content of care in interventions for FMP reveals what practitioners actually do in practice. Such information can be a first step towards identifying the optimal sequence, intensity and duration of elements within interventions for FMP, and can provide new possibilities to explain the effectiveness of interventions. It also suggests new ways to set up supervision of practitioners, eventually leading to better quality of care for these families.

Funding

This work was supported by the Netherlands Organization for Health Research and Development (ZonMw) [grant number 729300016].

Ethical approval

The Medical Ethics Committee of the University Medical Center Groningen in the Netherlands considered ethical approval unnecessary for this study (reference number METc2016.005 dated March 7, 2016).

CRediT authorship contribution statement

L. Visscher: Writing - original draft, Formal analysis, Conceptualization, Data curation, Investigation. **K.E. Evenboer:** Writing - review & editing, Supervision. **R.H.J. Scholte:** Writing - review & editing, Supervision. **T.A. van Yperen:** Writing - review & editing. **J. Knot-Dickscheit:** Writing - review & editing. **D.E.M.C. Jansen:** Conceptualization, Writing - review & editing, Supervision, Funding acquisition. **S.A. Reijneveld:** Conceptualization, Writing - review & editing, Supervision, Funding acquisition.

Declaration of Competing Interest

The authors declare that they have no known competing financial interests or personal relationships that could have appeared to influence the work reported in this paper.

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